Gynecologic Health History Questionnaire:

FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Name____ Date of birth______________________________

Address____

Local phone number_____________________________ Alternative phone number___________________

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe)____

Special Communication Needs:		
Language preference:		If 'yes' to any of the questions below, how can we assist?
Visual impairment	☐ Yes ☐ No	
Hearing impairment	☐ Yes ☐ No	
Speech impairment	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Sensory impairment	☐ Yes ☐ No	

Personal Health History	
Please check past(P) or current(C) problems or conditions	
P☐ C☐ Anxiety	P☐ C☐ Bladder Problems
P☐ C☐ Blood Disorder	P☐ C☐ Heart Condition
P☐ C☐ High Blood Pressure	P☐ C☐ Liver Problems
P☐ C☐ Hepatitis	P☐ C☐ Neurological Condition
P☐ C☐ Psychiatric Condition	P☐ C☐ Depression
P☐ C☐ Thyroid Disorder	P☐ C☐ Lung Disorder
P☐ C☐ Diabetes	P☐ C☐ **Cancer**
P☐ C☐ Breast Problems	Type: ______________________
P☐ C☐ Kidney Problems	P☐ C☐ Sexually Transmitted Disease
P☐ C☐ Abnormal Pap Smears	P☐ C☐ Other:________________
P☐ C☐ Stomach Problems	☐ No Current Medical Conditions

Previous Surgical Procedures	
Please check if you have had any of the following	
Procedure	Year
☐ Breast Surgery	
☐ Hysterectomy	
☐ Vascular surgery/stent	
☐ Spine Surgery ☐ Neck ☐ Back	
☐ Heart surgery	
☐ Other: ________________________	
☐ Joint replacement ☐ Hip ☐ Right ☐ Left ☐ Knee ☐ Right ☐ Left	

Gynecologic Health History
First day of last period: _________________
Menstrual flow: ☐ Reg. ☐ Irreg. ☐ Pain/cramps
Days of flow ________ Time between periods________
☐ Pain or bleeding after sex
☐ Vaginal bleeding/discharge
Menopause: ☐ Y ☐ N Age: __________
Birth control method ________________

Obstetrical Health History	
Number of pregnancies ______________	
Miscarriages________________ Abortions: _______________	
Pregnancy Term	**Type of Delivery**
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean
	☐ Vaginal ☐ Cesarean

Social History:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner **In a sexual relationship?** ☐ Yes ☐ No
Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Lesbian **Are you being sexually abused, threatened or hurt?** ☐ Yes ☐ No
Live here year round? ☐ Yes ☐ No If no, Part time location: ____
Occupation: **Concerns**: ☐ Stress ☐ Hazardous subst. ☐ Heavy lifting **Exercise:** ☐ No ☐ Yes: _____times/week
Tobacco use: ☐ Never ☐ Quit (when)_____________ ☐ Current smoker: Packs/day, how many years_______________________
Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often________________
Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often________________
Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current Describe:____

Family History

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Cancer: ☐ Breast	
☐ Heart Disease < 65 years of age		☐ Colon	
☐ Hypertension		☐ Ovarian	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations	Last Occurrence	Tests	Last Occurrence
Influenza vaccine ☐ Yes ☐ No		Mammogram ☐ Yes ☐ No	
Gardasil (HPV) vaccine rec'd ☐ Yes ☐ No		Pap smear/pelvic ☐ Yes ☐ No	
		Colonoscopy ☐ Yes ☐ No	
		Bone Density ☐ Yes ☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

ALLERGIES: Please list *any* allergies to medications, foods, or materials (including latex)

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: ____________________________ **Phone**: ________________ **Store #**: ________________

Location Description: ____

Additional Providers:

Primary Care Provider	**Other:** ______________________
Name: ______________________________	Name: ______________________________
Phone: ____________________ Last Seen: __________	Phone: ____________________ Last Seen: __________

Patient/Guardian Signature: ____ Date: ____________________